Policy Title:	Designated Record Sets
Policy Number:	AS-012
Effective Date:	July 1, 2013
Approval:	Thomas O. Forslund, Director — Date: 6/17/13

Purpose:
This policy distinguishes Wyoming Department of Health (WDH) records that are considered part of a designated record set pursuant to the Privacy Rule.

Scope:
This policy applies to all WDH workforce.

Definitions:
Designated record set means a group of records maintained by or for a covered entity that is the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or that is used, in whole or in part, by or for the covered entity to make decisions about individuals.

Protected health information (PHI) generally means identifiable or potentially identifiable health information that is transmitted or maintained in electronic media or any other form or medium. (For the complete definition, please consult 45 CFR § 160.103).

Record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity.

Policy:

1. **Inclusions.** The following PHI shall be considered part of a designated record set:
   a. Medical records, including, but not limited to:
      i. Advance directives;
      ii. Anesthesia records;
      iii. Care plans;
      iv. Consent for treatment forms;
      v. Consultation reports;
      vi. Discharge instructions;
      vii. Discharge summaries;
      viii. E-mails containing patient-provider or provider-provider communications;
      ix. Functional status assessments;
      x. Graphic records;
      xi. Immunization records;
      xii. Intake/output records;
      xiii. Medication orders;
      xiv. Medication profiles;

xv. Minimum data sets (MDS, OASIS, etc.);
xvi. Multidisciplinary progress notes/documentation;
xvii. Nursing assessments;
xviii. Procedure reports;
xix. Orders for diagnostic tests and diagnostic study results (e.g., laboratory, radiology, etc.);
xx. Patient-submitted documentation;
xxi. Pathology reports;
xxii. Practice guidelines or protocols/clinical pathways that imbed patient data;
xxiii. Problem lists;
xxiv. Records of medical history and physical examinations;
xxv. Respiratory therapy, physical therapy, speech therapy, and occupational therapy records;
xxvi. Selected waveforms for special documentation purposes;
xxvii. Telephone consultations; and
xxviii. Telephone orders.

b. Patient identifiable source data, including, but not limited to:
   i. Analog and digital patient photographs for identification purposes;
   ii. Audio dictation recordings;
   iii. Audio recordings of patient telephone calls;
   iv. Diagnostic films and other diagnostic images from which interpretations are derived;
   v. Electrocardiogram tracings from which interpretations are derived;
   vi. Videos of office visits;
   vii. Videos of procedures; and
   viii. Videos of telemedicine consultations.
c. Administrative data, including, but not limited to:
   i. Authorization forms for release of information;
   ii. Birth and death certificates;
   iii. Correspondence concerning requests for records;
   iv. Event history/audit trails;
   v. Patient-identifiable claims;
   vi. Patient-identifiable data reviewed for quality assurance or utilization management;
   vii. Patient identifiers (e.g., medical record number, biometrics); and
   viii. Protocols/clinical pathways, practice guidelines, and other knowledge sources that do not imbed patient data.
d. Derivative data, including, but not limited to:
   i. Accreditation reports;
   ii. Anonymous patient data for research purposes;
   iii. Best practice guidelines created from aggregate patient data;
   iv. MDS reports;
   v. OASIS reports;
   vi. ORYX reports;
   vii. Public health records; and
   viii. Statistical reports.

2. **Exclusions.** PHI contained within the following documents shall <u>not</u> be considered part of a designated record set:
   a. Quality improvement reports;
   b. Copies of reports/documentation already designated;
   c. Oversight activity reports/documentation;
   d. Research documentation;

e. Appointment schedules; and
f. Risk management records (including incident reports).

3. **Clients' privacy rights regarding designated records sets.** An individual has the right to:
   a. Inspect and/or obtain a copy of his/her PHI contained in a designated record set (paper or electronic) for as long as WDH maintains the PHI.
   b. Request that WDH amend PHI in a designated record set (paper or electronic) for as long as WDH maintains the PHI.

Contacts:
De Anna Greene, CIPP/US, CIPP/G, CIPP/IT, WDH Privacy/Compliance Officer, (307) 777-8664
Tate Nuckols, JD, WDH Security Officer, (307) 777-2438

References:
45 CFR § 160.103
45 CFR § 164.501
45 CFR § 164.530
Amatayakul, Margret et al. "Definition of the Health Record for Legal Purposes (AHIMA Practice Brief)." Journal of AHIMA 72, no. 9 (2001): 88A-H.

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